DOCUMENT RESUME

ED 255 313 PS 015 034

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TITLE Children Left Alone: Latchkey Problems--Future Research Questions and Interventions.
PUB DATE Feb 85
NOTE 11p.; Paper presented at the Annual Conference of the National Education Association (Washington, DC, February 22, 1985).
PUB TYPE Viewpoints (120) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *After School Programs; Birth Order; Childhood Attitudes; Children; *Employed Parents; Family Characteristics; Physical Health; *Predictor Variables; *Research Needs; *School Age Day Care; Self Concept
IDENTIFIERS *Latchkey Children

ABSTRACT

A brief discussion of some myths associated with latchkey children is followed by a statement that an insufficient number of after-school care programs for children makes it likely that children will continue in self-care or sibling care. It is suggested that future research endeavors take the following parental/familial variables into account: family size and structure, socioeconomic status, educational level of parent(s), parental attitudes toward working mothers and children in self-care, and parental expectations of children in self-care. The study of factors related to the child should include examination of the child's ordinal position in the family; self-care versus sibling-care; child's age when first left alone; hours left alone per day; child's sense of self; child care arrangements during vacations, holidays, and illness; child's attitudes towards the parents' job; child's attitude toward self-care, and child's health, including nutritional status, illnesses, school absenteeism, and injuries. The paper ends with a discussion of the role of physicians and teachers in becoming aware of what their patients/students do after school, on holidays, during vacations, and while ill. (AS)

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CHILDREN LEFT ALONE: LATCHKEY PROBLEMS-

FUTURE RESEARCH QUESTIONS AND INTERVENTIONS

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Presented at the 23rd NEA Annual Conference
Washington, D.C.
February 22, 1985

It is certainly an honor for me as a physician to address a group of educators. The field of education has been more attuned to the needs and problems of children in self-care, (i.e. latchkey children) than has been the medical field. I hope this will soon change because if each field contributes its own expertise and cooperates with the other, we can maximally assist the children to whom we have dedicated our professional lives.

I have been asked to talk about the future research that needs to be done on and the future solutions to children left alone. To do this, I would like to share with you some myths that are associated with the subject of latchkey children.

First Myth: "Latchkey status us either all good or all bad."

Fact: There are many variables that enter into the quality of one's"latchkey experience" such as the child's age, self-esteem, neighborhood, and the parent(s)' attitude toward a child in self-care. In addition, a child who has had a "good latchkey experience" one year may experience problems in a subsequent year, or vice-versa. It is probable that for many children the "latchkey experience" is neither all good nor all bad, but is a mixture of positive and negative aspects. Hopefully, for most of the time the positive outweighs the negative. It seems expedient that we learn to identify the children for whom the "latchkey experience" is mostly or totally a negative one, for these children are truly at risk.

Second Myth: "Latchkey experience" is a 3-6 PM phenomenon."

Fact: As other speakers have mentioned, the number of employed mothers in this country is on the rise. The media has catered to this phenomenon and has focused on the time that a child spends alone after school and before a parent comes home from work. However, in many families, parents must work swing-shifts, evening or night-shifts if they

want to be employed at all. In such families, the children may be alone for part or all of the night. Additionally, some children are in self-care because their parent(s) go shopping each day or "disappear" for several hours at a time.

The latchkey child issue is much more complicated than "the 3-6 PM phenomenon."

Third Myth: "Much is known about latchkey children because the results of previous studies are generalizable."

Fact: First of all, very few studies have been done. Secondly, the number of children in each study is usually not large. Thirdly, several studies investigated students from a single school which might introduce a selection bias which immediately limits the generalizability of the results. Fourthly, different studies come to different conclusions as to the "safety" of being a latchkey child.

The bottom line is that we still don't know enough.

Fourth Myth: "Supervision of children is good; no supervision is bad."

Fact: Poor supervision may, in actuality, be worse than no supervision, especially if the supervisor abuses the child in any way. If the child is old enough and has a healthy sense of self and responsibility, no supervision might not be detrimental. As with the first myth, a complicated issue is rarely an all-or-none phenomenon.

Fifth Myth: "All after-school care is the same."

Fact: Because children are individuals with individual needs, they respond to different types of care. One child might thrive in a structured after-school program while another does better spending his

after-school hours at a neighbor's house. In addition, sameness will never be a reality because of the great variation in the expertise of the providers who offer these services.

Sixth Myth: "Privately-funded care is preferable to publically-funded care."

Fact: In fact, some publically-funded facilities are superior to certain privately-funded programs, especially if the guiding force of the latter is generation of profit instead of service to children.

Given that in the forseeable future, there will not be enough after-school care programs for the number of children who need them, children in self-care or sib-care will always exist. What should we learn about them that we don't already know? In future research endeavors, what variables should be taken into account?

Parental/Familial Factors

1) Family Size and Structure : One's ordinal position in the family might greatly affect one's self-care of sib-care experience. In terms of sib-care, the experience of the care-giving sib might be drastically different from that of the care-receiving sib. Who has the more positive experience? We must get an estimate of the amount of abuse (physical, sexual, emotional) that occurs in sib-care arrangements and the factors that increase the likelihood of abuse. We should also investigate family structure: the self-care experience of a child whose single mother works might be totally different from the child whose single father works and from the child fron an intact family in which both parents work.

Can we make any generalizations about which child is likely to do better?

2) Socieconomic status: Working parents cross all socioeconomic strata. Some have argued that more affluent children do better (i.e. have fewer school and emotional problems as a result of being alone) than do poorer children. Some researchers have suggested that this is due to a variety of factors including the safer neighborhoods in which affluent children live. However, SES might also be associated with the mother's need to work and the child's understanding of that need. A child of a poor family might realize that his mother must work if the family is to survive and adjusts his expectations accordingly.

3) Educational level of parent(s): The expectation is that better-educated parent(s) produce more confident and self-reliant children but the converse may be true: parents with less education who live in less desirable neighborhoods might be more likely to instill self-survival and self-reliance skills in their children so that they will survive.

4) Parental attitudes toward working mothers and children in self-care: Very little attention has been paid to the father's attitudes and expectations. Presumably, this has been because there are more single working mothers than fathers and because of the belief that a mother's attitudes affect a child more than a father's. However, divorce courts are now awarding fathers more custody rights than ever before and both parents' attitudes affect a child, especially if they disagree and the child is caught in the middle. Also important is whether the maternal and paternal grandmothers worked when the parents were growing up since their attitudes as adults might be greatly influenced by their experiences as children.

5) Parental expectations toward her child in self-care: The previous item dealt with general attitudes; this one deals with parental feelings about her child. Parents who can correctly assess their child's ability to function alone (at an appropriate age) and who give the child both room to grow and room to experience minor setbacks are more likley to have a mentally-healthy child in self-care. A parent who must work, but doubts her child's ability to function

alone will convey this attitude to the child either implicitly or explicitly. If the child feels that the parent,whom he trusts, doubts him, his self-confidence is eroded. Also important is the method by which a child is prepared to be alone. How are successfully functioning latchkey children prepared to function alone? What can parents do to increase their child's chance of success? There are many "self-survival" courses to prepare children to function alone. Are they successful? Who uses them?

The child's factors

Given that the child's age, sex, and race are known, what other characteristics of the child should we investigate?

1) The child's ordinal position in the family: Already discussed.

2) Self-care vs sibling-care: Who really functions more self-reliantly - a child in his own care or one in a sibling's care? The child who is alone might be lonely and fearful which would mitigate a healthy experience. Depending on his age, the child in sib-care might either overly rely on his sib for all of his needs (which places a large burden on the care-giving sib) or might be the victim of constant bickering or frank abuse (physical, sexual, emotional).

3) The child's age when first left alone: Logically, a child first left alone at age 12 would be better equipped to handle himself and his environment than a child first left alone at age 8. Parental expectations are a factor here as well. In addition, if a child was initially in sib-care and then "graduated" into self-care, might he be better prepared to take care of himself than a similarly-aged child who was in self-care from the onset?

4) Hours left alone per day and the child's use of that time: The average length of time that latchkey children are alone each day is 3-4 hours. But how long are the children alone whose parents work evening or night shifts? In addition to the quantity of time alone, the importance of the quality of time alone cannot be overstated. Given a group of similarly-aged children who are alone for 3-4 hours/day, how do the more successful latchkey children spend their time? Parents have been urged by some experts to "structure" their children's time alone by leaving lists of things to do. But, how much "structuring" is too much?

5) The child's sense of self: A child with a healthy sense of self will likely function better alone than will a child with a poor sense of self. How does a successful latchkey child perform scholastically

(cognitively and emotionally), with peers, with adults, and as a family member? Several researchers have found that teachers could not consistently identify latchkey children in their classes based on classroom behaviors. If this is really the case, then it causes us to reformulate our ideas about one aspect of a child's life affecting other aspects. Perhaps the children in these surveys were all well-adjusted latchkey children who would not be expected to differ from children in other forms of after-school care.

6) The child's care arrangements during vacations, holidays, and illness: The child who stays alone for several hours after school each day might also have to be alone for entire days when he is on vacation or he is ill. Some researchers have pointed out that most latchkey children must stay indoors without any company when their parents are away. How do the parents of successful latchkey children handle vacations or holidays when the parents must work? How do the care arrangements for successful latchkey children differ from those for the less successful children, especially in times of illness? Finally, when schools unexpectedly close (such as for inclement weather), what contingency plans do working parents have?

7) The child's attitude towards the parent's job: A child who understands why his parent must work and is proud of his parent's occupation should be more successful as a latchkey child than one who resents his parent's job and absence. It would be important to compare the knowledge and attitudes toward parental employment of successful latchkey children with those of latchkey children who are less successful.

8) The child's attitude toward self-care: The child's attitude will be shaped by intrinsic factors (such as his fear of failing) and by extrinsic factors (such as fear of crime or emergencies, parental expectations, etc). Given that every child has both positive and negative feelings about being alone or being in sib-care, how can arents ensure that positive feelings will outweigh the megative ones?

9) The child's health: Virtually nothing is known about the physical health of children in self-care or sib-care. Some issues which might be examined include: a) nutritional status: How does the nutritional status (i.e. the degree of obesity or thinness) of successful latchkey children differ from that of less successful ones? How do these two differ from children in parent-care, sib-care, or other after-school care programs? Are children in self-care more likely to be obese because they eat when they're bored or lonely or more likely to be thin?

Such issues are important since we believe that childhood obesity antecedes adult obesity, which is associated with a number of chronic conditions. b) illnesses: Are latchkey children subject to more acute respiratory and gastrointestinal illnesses than other children are? Do they have more chronic complaints, such as headaches, stomachaches, sleep disorders, etc) than other children have? Chronic complaints in childhood might indicate depression or other emotional dysfunction. If latchkey children do experience more acute and chronic illnesses than do children in other forms of care, do they also make more visits to physicians than do other children? Or do they make fewer visits because their working parents cannot take them to the doctor during regular office hours? c) school absenteeism: Do latchkey children miss more days of school because of illness or fewer days of school because they come to school with illnesses for which children in parent-care would be able to stay home? Do latchkey children make more visits to the school nurse than other children? Are these visits more likely to be for acute or chronic problems? Do these visits usually result in dismissal from school? If so, what care arrangements are available for the child? d) injuries: Do latchkey children incur more injuries, even minor, when they're alone than do similarly-aged children at the same time of day in parent-care, sib-care, or other after-school care? What kinds of injuries are most frequently incurred? Does the incidence of injuries in successful latchkey children differ from that in less successful ones?

The research that can provide answers to these questions must be carefully planned and flawlessly executed. Such research endeavors will take time. What can we do NOW together and as individuals to assist children in self-care?

All who are interested in children can work together to help them. Though both are involved with the welfare of children, educators and pediatric health professionals have had either little chance or inclination to work with or learn from each other. Hopefully, this will change. Your attendance at this workshop demonstrates your interest. We in pediatrics should learn more about children in self- or sib-care, the contributions that researchers from the educational field have made to this subject, and the daily experiences that teachers have with students who are in self-care or in the care of siblings.

Physicians can become aware of what their pediatric patients do after school, on vacations, or during illnesses. A physician can easily explore these issues with both parent and child during visits for "check-ups." A physician should know the working status of all parents in his/her practice. Parents can be asked about routine and emergency care arrangements and their feelings about these arrangements. The child should also be asked what he does after school and during school holidays and his opinions regarding his activities. The physician should also be aware of available care programs in his/her community (including location, quality, and cost), or should be able to refer the parent to someone who can give this information. A physician can increase his/her knowledge of community resources through personal experience with programs or through personal reports of parents who use these programs. Such reports can be solicited when the parents bring their children in for rountine health care. In addition, a physician should also explore care arrangements when the child is ill. An optimal opportunity to do this is during a visit for illness.

Teachers can discover what their pupils do after school or on school holidays. Parents might be offended if teachers rountinely individually quizzed each pupil about their care arrangements before- or after-school. However, the subject can be broached in non-threatening ways. "What I do after school (or "before school" or "on holidays")" can be the subject of class discussions or an essay assignment. If it is part of a class discussion, <u>all</u> participants can be encouraged to verbalize their feelings about their out-of-school lives. In this way, teachers can identify both the latchkey children and the children who have negative feelings about their after-school activities. Discussions with the parents might be necessary, especially if these children are experiencing scholastic or emotional difficulties.

Teachers should also be aware of before- and after-school care programs in their communities either through personal research or through the reports of the parents and children who use them.

Both physicians and teachers should be as supportive as possible of parents whose children are in self- or sib-care. Such parents frequently feel guilty or fearful about these arrangements but feel that no other options are available to them. This might be an accurate assessment of their communities. However, frequently parents are unaware of valuable, but perhaps little-known, programs that are available.

It is useless to increase a parent's sense of fear or guilt if no other options are available. Instead, a non-threatening discussion of available community programs or possible alternate care arrangements is much more helpful.

All children, regardless of out-of-school care arrangements, should possess self-survival skills, such as what to do if a fire breaks out (especially in their homes), if assaulted, if injured, etc. I firmly believe that it is the parents' rimary responsibilty to impart this knowledge to their children and that su h responsibility should not be abrogated to teachers for several reasons. First of all, a teacher might give a child information with which a parent disagrees. Secondly, such instruction should begin as early as the preschool years when safety habits can be easily taught. Thirdly, in some cases, the teacher can't possibly impart accurate information. For example, more children die in house fires than in any other type of fires. To tell a child to get out of his house if it is on fire is not enough. Suppose the fire blocks the door or traps the child in his room. How does he escape? A teacher, who doesn't know the design of the child's house, might not be able to adequately explain the best way of egress to such a child. Teachers and physicians alike should remind parents of the necessity for ALL children to possess these basic survival skills. In some communities, courses are available for parents so that they might be better equipped to teach their children these skills. In addition, there are several excellent books for both parents and children on this topic. It is not enough for parents to give their child a book to read or a course to attend in this important area of personal health and safety. We as professionals dedicated to children should investigate the books and courses available in our communities so that we can meaningfully counsel parents about their quality and age-appropriateness. Finally, we can remind parents that the best method to prepare a child--to handle emergencies, to care for himself, to be a happy member of his family, his class, or society at large--is a loving, open, and accepting bond between parent and child, in which the parents know their child so well that they would never dream of asking him to perform beyond his limits. Such a relationship is built on love, trust, and open communication.